Developmental Disabilities Division

Wyoming Department of Health
Commit to your health.

Plan of Care Changes May 2009

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Training Agenda

- Changes to waivers
- Transitions needed
- New Plan of Care forms
- New IPC Instructions
- New Supplemental Forms
- New Plan expectations
- IBA, Pre-Approval, modifications, ECC
- Upcoming News and trainings

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CHANGES ARE HERE!

Applications were submitted to CMS March 31, 2009

- CMS has required significantly more information, description of safeguards and processes than in previous waiver renewals
- All proposed changes are subject to approval by CMS and may be revised prior to the waiver renewal start date of July 1, 2009
- There has been no feedback from CMS to date

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Services being removed

Prevocational Services

- Will be phased out by September 30, 2009 on all plans. Teams must meet and transition services to either day habilitation or supported employment services

In Home Support

- Will be phased out by September 30, 2009 on all plans. Teams must meet and transition services to personal care or supported living

<u>Notification will be sent to participants to make a change in service.</u>

Respiratory Therapy

- Not currently used, still available on the Medicaid State Plan

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Services Being Added

- **Supported Living** – A Habilitation service to assist persons with disabilities to live in their own home, family home, or rental unit. These individuals do not require ongoing 24-hour supervision but do require a range of community-based support to maintain their independence. They require individually-tailored supports to assist with the acquisition, retention, or improvement in skills related to living successfully in the community.
  - Daily unit ($93.40) cap= historical
  - 15 minute unit – group ($3.33) cap= 5400 units
  - 15 minute unit – individual ($8.70) cap = 3900 units

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Supported Living

- The Daily Unit or 15 minute group unit can be reimbursed for up to 3 participants
- Must choose either the daily unit or the 15-minute unit for the plan
- 15- minute group and individual may be on the same plan.
- Daily unit requires a minimum of 4 hours in service.
- Service includes personal care.

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Personal Care

- **Still a 1:1 service**
- **No training component required.**
- **New expanded definition.**
  - **See page 26 of the IPC Instructions for clarification on the new definition**
- **Includes assistance with Activities of Daily Living AND Instrumental Activities of Daily Living.**

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Intermittent Residential Habilitation

- Participants and case managers will be notified by letter to change services, if they are receiving the 1:4 tiered rate.
- If staff are not available on-site 24 hours a day, then the plan must be modified to either supported living or personal care.
- Both services cannot be on the same plan
- These changes must be made by Sept 30.

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Habilitation Changes

- Day Habilitation – daily unit requires at least 4 hrs of service
  - Also a 15 minute unit is available (not a tiered rate) ($3.12/unit) cap = 3750 units
- Residential Habilitation - daily unit requires at least 8 hours of service. Family visits or vacations are encouraged, so providers may bill on the day a participant returns from a trip.

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Targeting Criteria for Residential placements

- Applies to waiver participants, who are not receiving 24-hour residential services but are at significant risk due to extraordinary needs that cannot be met in current living arrangement, and anyone new to the waiver.
- All requests will go through the ECC process
- More information will be posted in June. Criteria begins July 1, 2009.

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Targeting Criteria

- **IMPORTANT:** No request for out of home residential placement will be considered without supporting documentation from professionals outside the DD system. The Division reserves the right to request DFS to conduct a review of the home situation.

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Services being modified

- Respite – cannot be used when caregiver is working – Maximum allowed 3000 units
- Personal Care – expanded to include activities such as shopping, budgeting – Maximum allowed 7280 units
- Supported Employment - includes Individual Community Integrated Employment and Group Supported Employment – rates have not changed

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Individualized Budgeted Amounts (IBAs)

For Adult & ABI participants and children receiving RH or SFHH…

IBAs shall be:

- Units from SFY-2009 approved plans multiplied by posted service rates.

The posted rates as of May 5, 2009 are subject to reduction based upon the Governor's potential budget cuts.

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Individualized Budgeted Amounts (IBAs)

For existing Children DD Waiver participants who do not receive residential services…

The revised IBA shall be

- The established IBA between July 1, 2008 and June 30, 2009 (SFY-2009) shall be the same IBA for SFY-2010.

The posted rates as of May 5, 2009 are subject to reduction based upon the Governor's potential budget cuts.

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The Division MAY adjust an IBA for the following reasons:

- If a subsequent assessment is required, the cost may be added to the plan for ONE YEAR ONLY, not to exceed $1,000.
- If the participant has transitioned to a different service due to waiver changes (i.e. From In-Home Support to Personal Care or Supported Living)
- If the participant has had a transition last plan year resulting from a substantial change in the person's health and safety needs.
- If significant changes in the participant's functioning occurs, and it can be substantiated by documentation provided by the case manager and/or a new ICAP, then the Waiver Manager shall calculate a new IBA based on this substantiated information.
- If the living situation changes to a less restrictive environment or if paid supports are reduced, the IBA will be adjusted accordingly.

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Team Meetings reminder

Transitions needed for:

- Prevocational services switching to either day habilitation or supported employment
- In Home Support switching to either Personal Care or Supported Living.
- Residential Habilitation (1:4 Intermittent) changes if staff are not on-site 24 hours a day

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QUESTIONS

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Plan of care changes

- Redundancy reduced
- Number of pages requiring signatures reduced
- New information required on risk assessment, conflict of interest, medication assistance, and employment planning
- Additional information required for reporting requirements as identified in the new waiver
- Plans must be submitted 30 days prior to plan start date. If an ECC is included, it must be submitted 40 days prior

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REVISED! More details and examples

Individualized Plan of Care (IPC) INSTRUCTIONS

Individualized Plan of Care instructions apply to any participant on the Adult DD, Children's DD, or ABI Waiver. This manual also includes guidance and instructions for all supplemental forms and documents relating to the IPC approval process.

Examples and prompts are provided in the IPC and in the instructions to initiate team discussion and capture specific details about the participant's supervision and support needs. Descriptions in the plan should be uniquely developed for the participant.

Forms, instructions, memorandums, samples,

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Inst. 6-6-05 Rev 4-09

INDIVIDUALIZED PLAN OF CARE

About Me!

Mark type of waiver: ☐ ABI ☐ Adult ☐ Child Participant Name Plan Start Date

Instructions: *The "About Me" section gathers information about the Participant's strengths, abilities, needs, preferences, desired outcomes and cultural background. Responses shall come from the participant and guardian, if applicable, and those who know the person best. This is the first section of the Individualized Plan of Care and the most important part for providers to "get to know" the participant as a unique individual. The supports, objectives, and schedules shall be developed using this information.*

If the Participant is answering the questions, then the responses shall be written in first person. If someone else is answering the questions, the responses can still be made in first person but it should be stated who is responding (i.e., My parents said, My team thinks, etc.) Also, list any other supports the Participant uses to communicate, such as a communication device, sign language, pictures, etc. Be as specific and thorough as possible in the responses. The italicized information is designed to facilitate the team's conversation with the Participant.

What I did last year:
(Include achievements, special events, detailed progress on habilitation objectives, personal goals, etc.)

People with whom I like to spend time:
(This could be family, friends, church members, employers, co-workers, providers, classmates. Then include how contact is made, i.e. phone calls, visitations, letters, e-mail and how to assist him/her in contacting others.)

What I like to do for fun:
(Include favorite activities, new leisure activities desired, hobbies, etc.)

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PERSON CENTERED PLANNING ISN'T NEW AND IT ISN'T HARD

- The Division uses the **"About Me"** section to and encourage person-centered planning.
- **It's Listening** to where a person wants to live and work, spend each day, to whom (s)he wants to spend time, & his/her future hopes and dreams
- **It's Supporting** a person in his/her "choices", preferences, joining (s)he with the same focus, strengthening personal relationships, and helping (s)he plan, act, and learn.

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Revised About Me Section

- Revised questions and prompts
- Replaced "Additional Behavioral Supports" page information into About Me questions
- Reminder to capture progress on past objectives in first question.

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More "About Me"

- Completed before team meeting, then reviewed with team at meeting
- Used to determine proper services, schedules, objectives, and supports
- It should record the participant's past progress on objectives and important changes happening in his/her life.
- Waiver Specialists use this section to check plan for supports and services reflective of the participant's wants, needs, and desires.

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Demographics changes

DEMOGRAPHICS	
Participant Information: Legal Name: Preferred name: Full Mailing Address: Physical Address: Phone Number: Emergency Contact Name: Emergency Phone #:	Social Security Number: ___ - ___ - ____ Medicaid ID Number: Date of Birth: ___ / ___ / ____ Age: Additional Insurance: Other Important Contacts: Relationship:
Legal Guardian: No ☐ Yes ☐ Full ☐ Limited ☐ Name: Full Mailing Address: Phone Number: Purpose: Relationship: Court order in Master file: ☐ Yes ☐ No ☐ N/A	**Conservator:** No ☐ Yes ☐ Name: Address: Relationship: Phone Number:
Representative Payee: No ☐ Yes ☐ Name: Address: Relationship: Phone Number:	**Case Manager contact information:** Name: Organization: Full Mailing Address: Telephone numbers, (ext): e-mail: Fax number:
Plan Start Date: Plan Start Date: **Team Meeting Dates (Month/year):** Annual Planning Meeting Date: Plan Review Date:	**Assessments:** Date of Psychological Evaluation: Date of ICAP: Current ICAP Service Score:

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Rights, Restrictions and Responsibilities

Refer to:

- Team Meeting Checklist
- Rights, Restrictions, and Responsibilities Tool on the website
- Page 4 of the plan
- Page 4 of the IPC Instructions

Discussion should include:

- Who has rights?
- What are rights?
- How may rights be limited? Is the participant under 18 years of age?
- Do participants have responsibilities?

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RIGHTS, RESPONSIBILITIES AND RESTRICTIONS

My Rights and Responsibilities as a waiver participant are explained in a rights document available on the Division's website. The team shall review my rights, restrictions and responsibilities at team meetings and as needed. Any right being restricted as part of waiver services must be explained in this section.

1. The "Rights, Responsibilities and Restrictions" document was made available and explained to me or my guardian/parent on _____ (date).
2. Are there physical or mechanical restraints in my plan? Yes ☐ No ☐
3. Are there restrictions of my rights? Yes ☐ No ☐ *If no, skip this section and draw a line through page.*

If yes, identify the specific right and address each column as it pertains to the restriction of the right.

Mark if the right is restricted	My Rights	Reason for the restriction (can check more than one) Health&Safety	Behavior	Guardian	How is the restriction imposed?	How will my team help me exercise my rights more fully?
☐	Keep and spend money	☐	☐	☐	☐ Rep. Payee or other:	
☐	Keep and use personal possessions	☐	☐	☐		
☐	Access to food or drinks	☐	☐	☐		
☐	Send and receive unopened mail	☐	☐	☐		
☐	Make and receive telephone calls	☐	☐	☐		
☐	Privacy in matters of activities of daily living	☐	☐	☐		
☐	Receive visitors, communicate and associate with person's of one's choice	☐	☐	☐		
☐	Be free of mechanical or physical restraints	☐	☐	☐		

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Deciding on Rights Restrictions

- Specific rights, as listed in the IPC Instructions, may be modified
- If restraints are used, then it must be listed as a restriction of rights
- Check IPC Instructions for rights of children

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Rights and Restrictions

Recording Rights Restrictions in IPC

All restrictions shall be identified on the Rights Restriction section of the Plan of Care *(refer to the IPC Instructions for help!)*

All restrictions shall identify the following:

- Right that is restricted
- Why the right is restricted (health & safety, behavioral, and/or guardian preferences)
- How the team will help the participant exercise the right more fully
- A date to review restrictions

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Services Available pg 5 in IPC

☐	**T-2016U9: Residential Habilitation** 2:1 daily	☐	**G-0152: Occupational Therapy** - Individual (Adult & ABI) 15 min.
☐	**W4000: Residential Habilitation Intervention** Hourly	☐	**G-0152UP: Occupational Therapy –** Group (Adult & ABI) 15 min.
☐	**T-2033: Special Family Habilitation Home** (Child) daily	☐	**G-0153: Speech Therapy-** Individual (Adult & ABI) 15 min.
☐	**T-2013: Residential Habilitation Training** (Child) hourly	☐	**G-0153UP: Speech Therapy -** Group (Adult & ABI) 15 min.
☐	**T2017: Supported Living -** Individual (Adult & ABI) 15 min.	☐	**T-2019: Individual Community Integrated Employment** (Adult & ABI) 15 min.
☐	**T2017UP: Supported Living -** Group (Adult & ABI) 15 min.	☐	**T-2019UQ: Supported Employment-** Group (Adult & ABI) 15 min.
☐	**T2016U8: Supported Living -** Daily (Adult & ABI)	☐	**S-9470: Dietician** 15 min.
☐	**T2021 Day Habilitation** (Adult & ABI) 15 min.	☐	**S-5165NU: Specialized Equipment** (New)
☐	**T-2020U4: Day Habilitation** 1:4 (Adult & ABI) daily	☐	**T-2029: Specialized Equipment** (Repair)
☐	**T-2020U3: Day Habilitation** 1:3 (Adult & ABI) daily	☐	**S-5165SU: Environmental Modification** (New)
☐	**T-2020U2: Day Habilitation** 1:2 (Adult & ABI) daily	☐	**S-5165: Environmental Modification** (Repair)
☐	**T2020U1: Day Habilitation** 1:1 (Adult & ABI) daily		**Identify all Non-Waiver Services utilized:** ☐ SSI, ☐ SSDI, ☐ Medicare, ☐ Other Medicaid plans ☐ DVR, ☐ School, ☐ Food Stamps, ☐ Housing Assistance, ☐ OT, ☐ PT, ☐ Speech, ☐ Mental health services, ☐ private health insurance ☐ transportation vouchers, other:
☐	**W4001: Day Habilitation Intervention** hourly		
☐	**T-1002: Skilled Nursing** 15 min.		

New

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MY MEDICAL SERVICES

Service	Name of Doctor or Specialist	Recommendations	Last visit	Next Visit	Who will assist me?*
Annual Physical					
Annual Dental Cleaning					
Other Dental					
Eye Exam					
Other Optometry					
Specialty exams:					
Neurology					
Psychiatry					
Psychology					
Speech					
Hearing					
Dietician					
Physical Therapy					
Occupational Therapy					
Other:					

New

****** Submit with ICAP*******

Pg 6 in IPC
Pg 9 in Instructions

*Assistance can be provided by a parent, guardian, relative, respite, case manager, staff person or anyone who agrees to see the medical services through. All results should be reported back to the case manager so necessary information may be shared with providers on a need to know basis.

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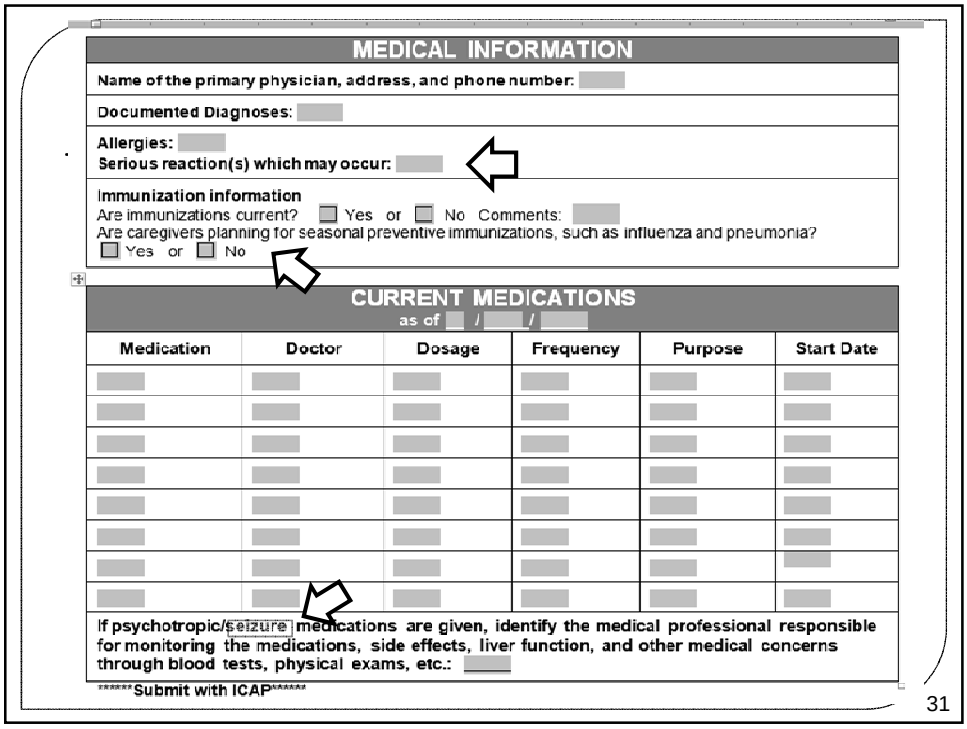

MEDICAL INFORMATION

Name of the primary physician, address, and phone number:

Documented Diagnoses:

Allergies:
Serious reaction(s) which may occur:

Immunization information
Are immunizations current? ☐ Yes or ☐ No Comments:
Are caregivers planning for seasonal preventive immunizations, such as influenza and pneumonia?
☐ Yes or ☐ No

CURRENT MEDICATIONS

as of ___ / ___ / ___

Medication	Doctor	Dosage	Frequency	Purpose	Start Date

If psychotropic/seizure medications are given, identify the medical professional responsible for monitoring the medications, side effects, liver function, and other medical concerns through blood tests, physical exams, etc.:

*****Submit with ICAP*****

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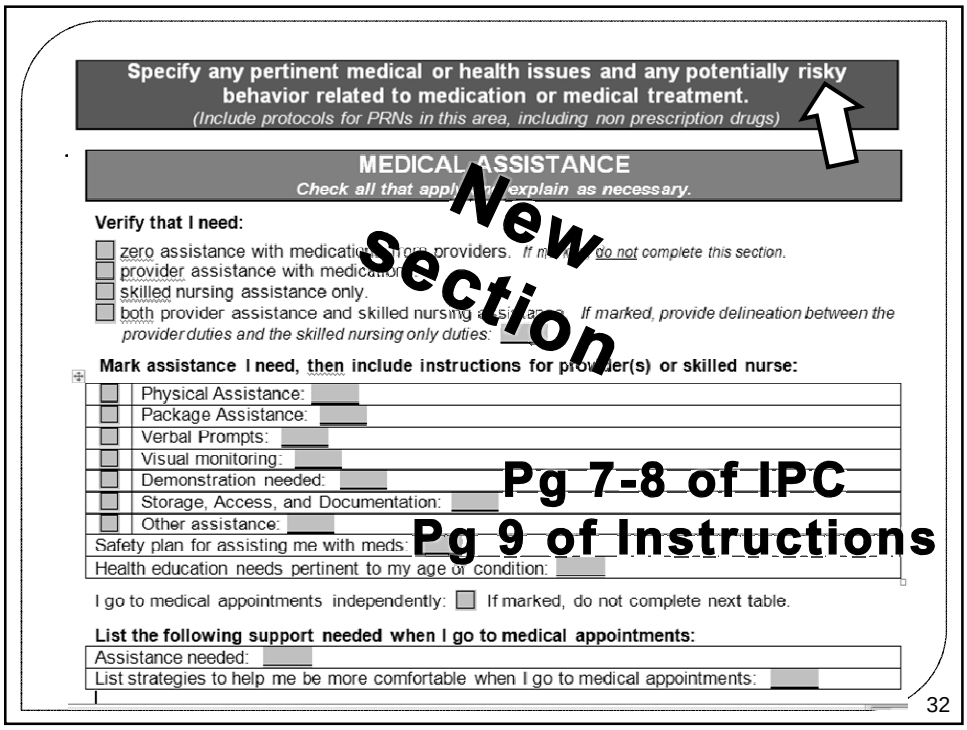

Specify any pertinent medical or health issues and any potentially risky behavior related to medication or medical treatment.
(Include protocols for PRNs in this area, including non prescription drugs)

MEDICAL ASSISTANCE

Check all that apply & explain as necessary.

New section

Verify that I need:

☐ zero assistance with medication from providers. *If marked, do not complete this section.*
☐ provider assistance with medication
☐ skilled nursing assistance only.
☐ both provider assistance and skilled nursing assistance. *If marked, provide delineation between the provider duties and the skilled nursing only duties:*

Mark assistance I need, then include instructions for provider(s) or skilled nurse:

☐	Physical Assistance:
☐	Package Assistance:
☐	Verbal Prompts:
☐	Visual monitoring:
☐	Demonstration needed:
☐	Storage, Access, and Documentation:
☐	Other assistance:
Safety plan for assisting me with meds:	
Health education needs pertinent to my age or condition:	

Pg 7-8 of IPC
Pg 9 of Instructions

I go to medical appointments independently: ☐ If marked, do not complete next table.

List the following support needed when I go to medical appointments:

Assistance needed:	
List strategies to help me be more comfortable when I go to medical appointments:	

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Medication Assistance Standards

- Long been a gap – there has been no standardized training for direct service professionals who routinely assist with medications
- Training will be developed by July 1, 2009 *(working group already in place)*
- Will have a Train-the-trainer model
- All providers assisting with medications must be trained by December 31, 2009

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Minor Revisions

- Seizure Information page
- Specialized Equipment List

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Major Revisions

- All About Where I Live and About My Day pages are combined
- Now called the "My Services and Supervision Profile"
- New questions added regarding risk assessment and safety plans
- Home and Day Site Supervision description now in this section, not in the "My Supports" area

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MY SERVICES AND SUPERVISION PROFILE

Check IPC Instructions for more details

Describe my home setting: *(mark all that apply)*

- ☐ With Parents
- ☐ With extended family or friends
- ☐ Foster Home
- ☐ SFHH
- ☐ Own home/Apartment—alone
- ☐ Own home/Apartment—with roommate(s)
- ☐ Residential Habilitation Home, with ___ housemate(s)
- ☐ Other: ___

Identify the waiver services provided in my home: ___

Identify how I spend my day. (*Describe my waiver services, non-waiver services, school, work, and/or other regular social and volunteer activities. Include average number of hours in each service.)*

___

The health and safety of myself or others is at risk due to the following behavior(s) in my home or provider's facility: *(List items such as elopement, exploitation, aggression, pica, etc.)*

___

The health and safety of myself or others is at risk due to the following behavior(s) in public places: *(List items such as falling risks, quick to develop sun burns, elopement, exhaustion, vandalism, aggression, illegal activity, etc.)*

___

My team will help me be safe in these situations by: (*Describe the strategies to minimize the occurrence of risky behavior, special accommodations or items used to help me be safe.)*

___

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Describe my supervision during waiver services: *(Include supervision and supports needed in my home, at the day site, in the community, and for special activities. Please be specific for different environments.)*

I need assistance or monitoring during sleeping hours to stay safe: ☐ **No** ☐ **Yes**
If yes, describe the support needs, any equipment used, frequency, and documentation requirements:

The following questions only apply if I receive residential and/or day habilitation services.

My approved staffing ratio in the home is:

My approved staffing ratio at the day site is:

If I receive Intervention Hours, specify residential and/or day habilitation usage, how the additional staff person for intervention is accessed, and what the intervention will be utilized for:

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WON'T PAY form is GONE!
Annual DVR contact is GONE!

(unless needed)

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EMPLOYMENT INTERESTS, ACTIVITIES, AND SUPPORT

The following only applies if I am employed or receive reimbursement for work through objectives at Day Habilitation.

☐ **THIS SECTION DOES NOT APPLY TO ME.** *If marked, go to "My Supports" section.*

Description of the work I do: ____ **Average hours a day:** ____ **Where:** ____

My work is considered: *(mark all that apply)*
- ☐ Independently Employed
- ☐ Individual Community Integrated Employment
- ☐ Group Supported Employment
- ☐ Part of a habilitation objective, and I am not competitively employed

Describe the supervision I need at during my work or training:

____

I need the following accommodations:

____

Pg 11 of IPC
Pg 12 of Instructions

I like my current job: Yes ☐ or No ☐ Comments about my job satisfaction: ____

In the future, I would like to explore other jobs, such as:

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Determining the Payer for Supported Employment

Supported employment services rendered under the waiver are only reimbursable if they are not available under a program funded through the Wyoming Division of Vocational Rehabilitation (DVR). To determine if DVR will or will not pay for services, answer the following questions. Additional guidance for this section is located in the IPC instructions. An "Employment Services Form" is required if the waiver supported employment is requested.

Do I have a community job or want to pursue community employment at this time?

☐ **YES**, *then DVR may be able to provide supported employment.*

☐ **NO**, *then waiver will pay for services based upon need and budget availability.*

Why is supported employment not available through DVR to meet my needs? ____

Have I had a DVR case open in the past? ____ **If so, when was it closed and was it a successful closure?** ____ *DVR may provide this information if the person requesting the information has a release of information with DVR or if the participant or guardian requests the information.*

When did I, or my case manager, last contact DVR for assistance? ____
Contact is not required annually, but as needed for pursuit of community employment.

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MY SUPPORTS

Check all boxes that are appropriate and explain items as needed.

Communication:

☐	I can verbally communicate
☐	I communicate using ☐ gestures, ☐ sounds, ☐ sign language, ☐ communication device
☐	I need someone to communicate for me. Assist me by:

Self-Advocacy: *(Speaking one's mind in matters important to him/her)*

☐	I can make my desires and concerns known to people who can fix things
☐	Although I can make my desires and concerns known to people I know, I need assistance by:
☐	I need total assistance to advocate, specify how:
☐	My family/guardian advocates for me

Transportation:

☐	I do not need assistance to transport myself
☐	I use public transportation, specify:
☐	I need transportation assistance to activities, specify by whom:

Mobility:

☐	I can walk independently
☐	I can walk with the following assistance or assistive devices:
☐	I use a wheelchair part or all of the time, specify:
☐	I have high risk of falling or being unsafe when walking, so try to keep me safe by:
☐	Positioning and/or transfer needs. *Give directions for positioning, transfers, and frequency:*

Assess risk, Create safety plan

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Money transactions:

☐	I can manage and budget my money independently
☐	I need assistance with budgeting and check writing
☐	I can keep up to $ on my person
☐	I can exchange money for purchases
☐	Exploitation risk:
Safety plan:	

Safety risks in the home:

☐	There are no safety concerns in my home to address
☐	Kitchen:
☐	Bathroom:
☐	Stairs or other parts of the home:
☐	List specific support or safety precautions:

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NOTICE OF CHOICE form is GONE!
RIGHTS SIGNATURE form is GONE!

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PARTICIPANT / GUARDIAN VERIFICATION

Participant/Guardian approval of plan: This Individualized Plan of Care has been carefully planned and coordinated with my active involvement and/or my guardian if I have one. The plan has been individually tailored, establishing schedules, services, and objectives that incorporate my unique needs and preferences. The necessary providers, family, friends, advocates, or medical professionals have been involved in the plan's development and the evaluation of its continuing appropriateness. I have been present, encouraged, and/or involved to the fullest possible level during the development of my plan of care,

It has been explained that the intended purpose of this plan is to help me maximize my independence and lead a productive life and that I, or any member of my team, may ask for another meeting at any time during the next 12 months to make a request for major changes to this plan.

It has also been explained that information about my participation in waiver services and my progress will be monitored by the Wyoming Department of Health and/or its ARF. I and/or my guardian have been assured that this information will only be used by authorized persons and my rights to confidentiality have been explained to me, and I understand that each provider on my team will receive either a copy of my plan, or portions of my plan, which are pertinent to the service they provide.

Major Revisions

Pg 14 of IPC
Pg 17 of Instructions

Participant or Guardian shall verify the following:

Yes ☐ **No** ☐ I have participated in the development of this plan and acknowledge my responsibilities as a waiver participant.

Yes ☐ **No** ☐ The restrictions in the rights and restoration plan have been explained to me along with my responsibilities.

Yes ☐ **No** ☐ I agree with the rights restrictions and restoration plan. **Comments:** _____

Yes ☐ **No** ☐ I have reviewed my choices through a provider list and have reviewed the waiver services available. I know I have a choice between home and community based services and the Wyoming Life Resource Center. I understand I can contact my local Area Resource Specialist at the Division to review possible changes to my providers. For this plan, I have made an informed choice about my providers.

Yes ☐ **No** ☐ I have been informed of my right to a Fair Hearing. I can call 1-800-510-0280 for clarification.

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CONFLICT OF INTEREST

pg 14 of IPC and pg 17 of Instructions

Conflict of Interest disclosure, if applicable:

A conflict of interest is a situation in which an individual has competing or conflicting interests or loyalties.

Case Management is a stand-alone service and I can choose a case manager not affiliated with any of my other services. If a case manager is providing other services on my plan, or the organization the case manager works for provides other services, it can be a conflict of interest. This applies to me: **Yes** ☐ **No** ☐

If yes, then address the following questions:

- How will the case manager assure the development of the plan of care is in my best interest? _____
- How is the case manager going to assure monitoring the implementation of the plan of care is in my best interest? _____
- How does the case manager assure my choice of providers? _____

Look at Instructions for sample wording

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Narrative Change & Team Demographics combined with Signature Page

TEAM SIGNATURES AND INFORMATION

Team members' approval of plan: By signing the plan of care below, I, as a team member, acknowledge the confidential nature of the information presented and discussed. As a member of this team, I have participated in the development of this plan, either by submitting service summaries and/or by attending the team meeting. I agree that this plan of care is a true reflection of discussions and recommendations submitted during the development of this plan. I agree to implement the plan of care as approved by the Division. I understand that the Division has final approval of the plan, and if there are changes to the plan during the approval process, the case manager will notify all team members.

Signature	Printed name	Relationship/ Service Provided	Phone/Fax Numbers	E-mail and/or Physical Address	Date
		Participant			
		Guardian			
		Case Manager			

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Objectives

See pg 21 of IPC Instructions

SMART OBJECTIVES

- **S**pecific
- **M**easurable
- **A**ttainable
- **R**elevant
- **T**ime Specific and **T**rackable

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Objectives

Objectives are required for all habilitation services:

- Residential Habilitation
- Special Family Habilitation Home
- Day Habilitation
- Res Hab Training
- Supported Employment, Community Integrated Employment (Own service page)
- Supported Living (Own service page)

An objective must be taught for each time period billed

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SUPPORTED LIVING SERVICE FORM

- ☐ T2016UB Supported Living (daily unit)
- ☐ T2017 Support Living (15-minute unit)
- ☐ T2017UP Support Living (15-minute unit, group)

Provider: _____ Units: _____

OBJECTIVE

My Objective is: _____

How will this objective help me? (meaningful) _____

How will this objective indicate how I am doing? (measurable) _____

If this objective is continuing from the previous plan, indicate past progress made and how the objective will change to attempt more success this year: _____

METHODOLOGY

Describe the training activities and strategies used by providers to help me achieve my objective: _____

Do I live with a family member or caregiver?
Yes ☐ No ☐ *If yes, the Circle of Support is optional.*

CIRCLE OF SUPPORT

This contact information shall be posted in my home so I can access assistance as needed.

Situation	Contact Person	Phone Number

Also included on Personal care service form

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EMPLOYMENT SERVICE PAGE

Name of Participant: _____ Start Date: _____ Review Date: _____

- ☐ T2019 Individual Community Integrated Employment
- ☐ T2019UQ Group Supported Employment

Provider Responsible: _____ ___ Units

Employment Objective

My employment objective is: _____

How will this objective help me keep my job or find a job? (meaningful) _____

How will this objective indicate how I am doing? (measurable) _____

If this objective is being continued from the previous plan, indicate past progress made and how the objective will change to attempt more success this year: _____

Methodology

Describe the training activities that will help me achieve my employment objective: _____

Describe the methods used to do the training: _____

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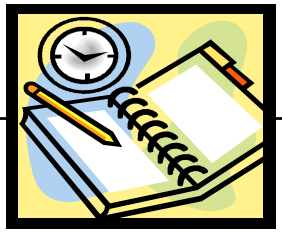

Schedules

- Schedules are the tools needed for billing documentation and proof that services were provided.
- Schedules must be submitted for all Habilitation, Respite, Personal Care, and Homemaking Services.

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Schedules

Schedules should be developed using comprehensive information about the participant, including:

- The "About Me" , "My Waiver Services and Supervision Profile," and "My Supports" sections
- The "Positive Behavior Support Plan"
- And any other pertinent information discussed at the plan of care meetings.

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Schedules

All schedules must include:

- Participant name, Provider name
- Location of service
- Plan date
- Number of units to be used per day/week/month
- Name of service or service code
- Date of service
- Actual, specific, personalized activities of the participant
- Notes/comments section
- Times in and out of service
  - Must be documented using either AM/PM or military
  - Provider signature on each page

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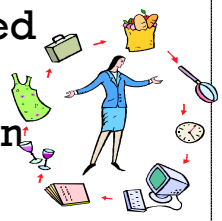
Schedules

- All schedules for the Adult and ABI Waivers require supervision levels to be listed.
- Brief description of supervision needed, as specified in the "My Waiver Services and Supervision Profile" section of the IPC.
- Staffing ratios do not have to be included unless the person requires 1:1 or higher.
- Task analysis may be a separate document from the service schedule.

54

Schedules

- If schedules are more than one page long, the same header information and signatures are required on each page.
- Schedules can be created in any format which includes all of the required information.
- Sample schedules are posted on the Division website at: http://wdh.state.wy.us/ddd/ddd/ipcforms.html



55

Questions?

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Positive Behavior Support Plans

- Must be based on a Functional Behavioral Analysis, sample of an FBA is on the DDD website
- Must meet criteria in Chapter 45, Section 29.
- If restraints are used, the use of restraints shall meet the criteria in Chapter 45, Section 28.
- Include PBSP after the "My Supports" section in the plan of care.

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Positive Behavior Support Plans

Revising the PBSP as Needed

- Review at least quarterly for effectiveness
- If plan is not working, gather team and review - don't wait for the 6 month or annual meeting

58

Restriction and Restraint Reporting

- The Division will begin requiring quarterly reports on the number of restraints and restrictive measures used for each participant on the waivers.
- Requirement will be discussed in a future training.

59

Preapproval Form

- Plan Services and Units Within the Budget Provided
- If a plan exceeds the IBA, the request shall go to the Extraordinary Care Committee (ECC)

60

Pre-approval Form No changes

Pre-approval Form of ABI/DD HCBS Waiver Services – Wyoming Developmental Disabilities Division (DDD)

☐ **Check if this is a Modification of an Approved Plan – Modification Effective Date** *mm/dd/yyyy*: ____

$____ Individually-Budgeted Amount (IBA)

0 6 - ____ Participant Medicaid Identification Number

___ - __ - ___ Participant Social Security Number

Name: Last, First, Middle Initial

Date of Birth *mm/dd/yyyy*

Plan Date *mm/dd/yyyy*

Name of Individually-Selected Service Coordinator, Case Manager, QMRP

ISC NPI Number (Individually-Selected Service Coordinator)

Procedure Code	Type of Procedure or Service	Provider Number (9-10 Digits)	Provider's Name	Total Units Used (12 Months)	Procedure Rate (Dollars Per Unit)	Total Cost (For 12 Months)	(Mod) Units Changed ↑	↓
____	____	____	____	____	____	____	☐	☐
____	____	____	____	____	____	____	☐	☐
____	____	____	____	____	____	____	☐	☐
____	____	____	____	____	____	____	☐	☐
____	____	____	____	____	____	____	☐	☐
____	____	____	____	____	____	____	☐	☐
____	____	____	____	____	____	____	☐	☐
____	____	____	____	____	____	____	☐	☐
____	____	____	____	____	____	____	☐	☐
					Total $	____		

Signature of Guardian

Date of Signature

☐ Approved by DDD

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Preapproval Form

- Include services on the pre-approval that have been identified in the IPC as needed services and use historical units
- The team must plan services and units for the plan year.
- Exceptions to historical units will be considered only for transitions or critical health and safety changes, which occurred within the last year.
- Participant or Guardian signature is required before it will be approved.

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Modifications

- See the IPC Instructions for submitting a modification to the plan of care
- There are new requirements in the instructions , so they must be used to complete modifications.
- The Division has 7 days to review a complete modification packet.

63

Extraordinary Care Committee

- The Extraordinary Care Committee Policy, Procedure, and forms are on Division's website
- Revised forms will be available July 1, 2009
- The case manager submits the completed ECC forms and additional information to the waiver specialist to review and present to ECC.
- The completed case will go to ECC within 10 days of submission. Incomplete cases or cases that do not meet the ECC criteria will not be reviewed.

64

Supervision Levels

pg 18 of IPC Instructions

- The ICAP score - starting point for suggested supervision level
- Review the Supervision Level Descriptions in the IPC Instructions
- Choose the description that best fits, and the plan of care must support this supervision level
- Supervision level and Intervention Request form is only needed if more supervision is being requested than the current plan

65

Intervention

ervention can be used for situations where
articipant's standard supervision level
y not provide sufficient staffing for specific activities or events, but the supervision level is not needed at all times.

- It is expected that a participant will receive 1:1 support at times specified in the IPC for assistance with ADLs and for objective training, regardless of the supervision level.
- Intervention is another person who comes in to meet a person's critical health and safety needs.

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IPC Technical Checklist

(Revised May 2009)

IMPORTANT: *The Plan of Care and the technical checklist must be received by the Division* ***at least 30 days*** *prior to the plan start date. All signatures shall be obtained* ***before*** *submission of the plan of care, or it will be considered incomplete.*

Type of Waiver (Mark One):

- ☐ Adult DD Waiver
- ☐ Children DD Waiver
- ☐ ABI Waiver

Waiver Participant Legal Name

Plan Start Date

Case Manager/Organization

Waiver Specialist Name

Individualized Plan of Care and Supplemental Forms

Check items submitted with the plan of care. Submit items in the order below.
Waiver specialists will not review plans until all components have been received.

Two Pages

- ___ **Extraordinary Care Committee Request Packet** (If plan amount exceeds IBA)
- ___ **Supervision level and/or Intervention Request Form** (If requesting more supervision or intervention)
- ___ **Pre-Approval Form**
- ___ **LT-MR-104/LT-ABI-105 Form**
- ___ **Guardianship Information**
- ___ **ICAP Summary Form (3 Forms)**
- ___ **Psychological or Neuropsychological Report**
- ___ **Medical Report**

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WAIVER SERVICES REQUIREMENTS

Mark all components included in the plan of care.

WAIVER SERVICE CODE	ADDITIONAL INFORMATION REQUIRED
Case Management	____Completed Conflict of Interest disclosure, if applicable. Otherwise, no forms required with plan.
___ Cognitive Retraining	____Service Page
___ Day Habilitation ☐ Daily ☐15 min/group	____Schedule ____ Objective Page
___ Day Habilitation Intervention	____Supervision Level and Intervention Request Form ____Schedule
___ Dietician	____Service Page ____Physician's Order ____Treatment letter or recommendation
___ Environmental Modifications (New) ___ Environmental Modifications (Repairs)	____Recommendations ____Photos or drawings ____2 quotes ____Materials list
___ Homemaker	____Schedule ____Service Page
___ Individual Community Integrated Employment	____Schedule ___ Employment Service Form
___ Residential Habilitation Trainer	____Schedule ____ Objective page
___ Occupational Therapy – Individual ___ Occupational Therapy – Group	____Service Page ____Treatment letter or Recommendation
___ Personal Care	____Schedule ____Service Page
___ Physical Therapy – Individual Physical Therapy – Group	____Service Page ____Physician's Order Treatment letter or recommendation

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IPC Submission Requirements

- The Division will only review complete plans.
- A complete plan has
  - all necessary sections completed,
  - all required forms for eligibility,
  - all service objectives, forms, schedules, and
  - ALL NEEDED SIGNATURES!

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Only 5/09 forms shall be accepted for July plans and after

IPC FORMS REVISED 5-09	CASE MANAGEMENT FORMS
Individual Plan of Care Form - Locked Version - Unlocked Version *(revised 5/09)*	ICAP Checklist - Locked Version - Unlocked Version
IPC Instructions (pdf) *(revised 5/09)*	Transition Checklists
Pre-Approval -- Locked version - Unlocked version *(revised 2/08)*	Targeted Case Management Forms
Supervision Level and/or Intervention Request - *(revised 5/09)*	Non-Compliance Form
IPC Technical Checklist - *(revised 5/09)*	Monthly & Quarterly Reports
Rights, Responsibilities and Restrictions Tool	Team Meeting Checklist in PDF
LT-MR 104	
LT-MR 105 - ABI Only	Extraordinary Care Committee (ECC) Request Form
	ECC Policy & Procedure
WAIVER APPLICATION RESOURCE GUIDES	**SERVICE & THERAPY OBJECTIVE PAGES REVISED 5-09**
Adult Waiver Resource Guide	Habilitation
Child Waiver Resource Guide	Supported Living
ABI Waiver Resource Guide	Employment
Adult & Child Psychological Requirements in PDF	Personal Care

70

Skilled Nursing reminder

- Physician's order has changed
- Requires physician involvement and signature, not a stamp
- Can only cover services that a trained direct care staff cannot perform.
- Will be carefully looking at services on form and need more information on the frequency of services needed.
- Home and Community Based providers are not skilled nursing facilities, so only services of medical necessity can be covered.

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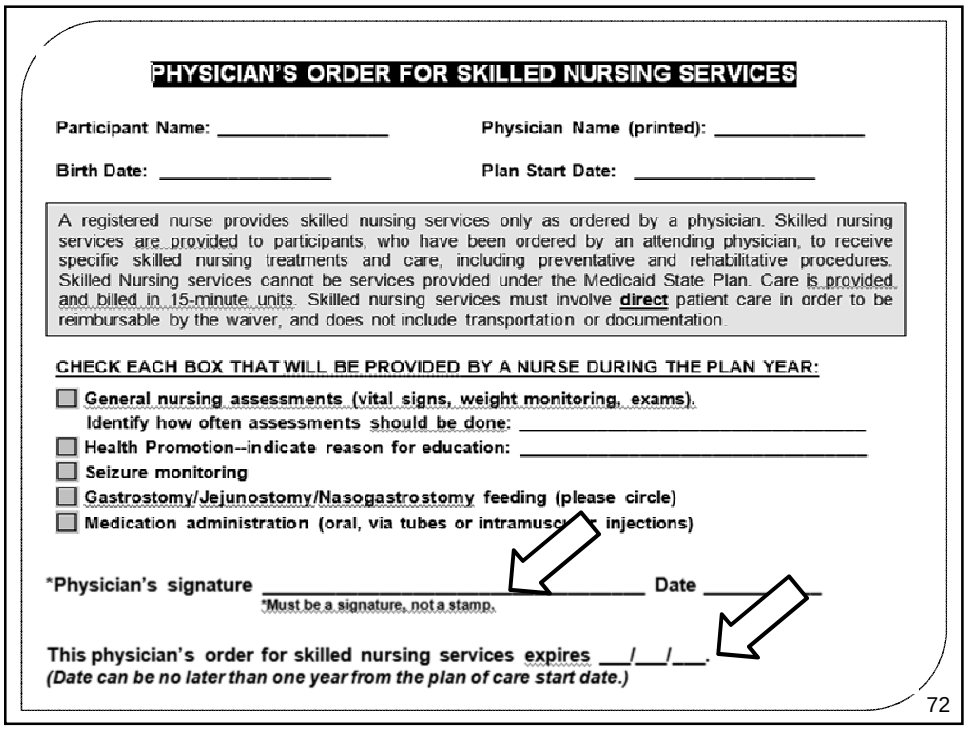

PHYSICIAN'S ORDER FOR SKILLED NURSING SERVICES

Participant Name: _____ Physician Name (printed): _____

Birth Date: _____ Plan Start Date: _____

A registered nurse provides skilled nursing services only as ordered by a physician. Skilled nursing services are provided to participants who have been ordered by an attending physician, to receive specific skilled nursing treatments and care, including preventative and rehabilitative procedures. Skilled Nursing services cannot be services provided under the Medicaid State Plan. Care is provided and billed in 15-minute units. Skilled nursing services must involve **direct** patient care in order to be reimbursable by the waiver, and does not include transportation or documentation.

CHECK EACH BOX THAT WILL BE PROVIDED BY A NURSE DURING THE PLAN YEAR:

- ☐ General nursing assessments (vital signs, weight monitoring, exams).
  Identify how often assessments should be done: _____
- ☐ Health Promotion--indicate reason for education: _____
- ☐ Seizure monitoring
- ☐ Gastrostomy/Jejunostomy/Nasogastrostomy feeding (please circle)
- ☐ Medication administration (oral, via tubes or intramuscular injections)

*Physician's signature _____ Date _____

*Must be a signature, not a stamp.

This physician's order for skilled nursing services expires ___/___/___.
(Date can be no later than one year from the plan of care start date.)

72

Rules Updated needed

- Chapters 41-45 will be re-opened and updated to reflect the approved waiver processes
- Chapter on Case Management will be re-written
- New chapters will be written on Medication Assistance and Rate Methodologies

As always, working groups will be identified. The Division would like input from providers, families, and participants

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About the Children's waiver

- This waiver is not up for renewal until March 2010 but some changes will occur
- Changes in the plan of care will be adopted by the Children's waiver
- All case managers will be required to have their own provider number
- Providers who assist with medications must receive training by December 31, 2009

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What about Children's services

- Respite for children will remain at 7280 units and how that service is used will not be scrutinized
- Other services should not change
- Children who wish to move to Residential Habilitation or Special Family Habilitation Homes must meet the targeting criteria

75

5 or 10 % Reduction

- The Division has presented a plan to the Department of Health
- This will be presented to the Governor in May, 2009
- The Governor will make final decisions if this reduction is needed and how it will affect each Division

76

Case Management Changes

- The name of the service is Case Management not Individually Selected Service Coordination
- All case managers will be required to obtain their personal provider number
- Organizations will continue to receive payment for those case managers who work for them
- A statewide training will be scheduled.

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UPCOMING TRAININGS

- ✓ Case Management changes
- ✓ Approved Medication Assistant Training
- ✓ Regional trainings for **all** team members
- ✓ Public meetings regarding Support Options Waiver

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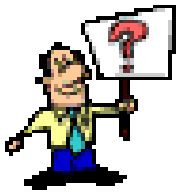
Questions?



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